Office of the Healthcare Advocate
STATE OF CONNECTICUT

Testimony of Victoria Veltri
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Before the Legislative Program Review and Investigations Committee
In Re a Study Concerning
Access to Substance Use Treatment for Privately Insured Youth
June 29, 2012

Good morning, Senator Fonfara, Representative Rowe, Senator Kissel, Representative Mushinsky, and members of Program Review and Investigations Committee. For the record, I am Victoria Veltri, State Healthcare Advocate. The Office of the Healthcare Advocate ("OHA") is an independent state agency with a three-fold mission: assuring health care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

I'd like to commend the committee for its initiative in studying the scope and impact of this very serious problem facing Connecticut's youth. Despite continued efforts by local, state and national agencies and advocates, substance abuse among adolescents between 12 and 17 remains an ongoing problem that has evaded adequate and equitable management by health insurers. Early and comprehensive intervention remains the standard for successful treatment of substance abuse and associated co-morbidities, yet only 10 to 15 percent of adolescents with substance abuse disorder (SUD) seek intervention and treatment.[1] Given the prevalence of drug use by Connecticut adolescents--10.9% had used an illicit drug and 20.8% had used alcohol within the past month--this is not something that we can afford to ignore any longer.[2]

Access to affordable care and an appropriate and clinically indicated duration of treatment

remains elusive for many in this target population, with health carriers routinely denying more intensive treatment modalities recommended by the adolescent's treating clinicians, most frequently citing a lack of medical necessity as a basis for the denial. My office sees that often the carrier's stated rationale is grossly inconsistent with clinical practice guidelines or the medical record. No entity other than the carrier or utilization management entity is responsible for ensuring that carrier'ss or utilization management entity's medical necessity criteria is based on sound clinical guidelines, with reference to "peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment," as required by Connecticut law. The carrier's or utilization management company's' sole responsibility is to assure the Insurance Department that their criteria comply.

The Insurance Department (CID) does not review criteria to ensure they comply with the statutory definition of medical necessity. And though OHA has requested CID's review of criteria, CID's limited review has resulted in narrow construction of one carrier's mental health and substance use disorder criteria, leading OHA to refer at least one carrier to HHS and DOL for violations of the Mental Health Parity and Equity Addiction Act. An investigation is ongoing. Clear statutory standards coupled with consistent, effective and vigilant enforcement are desperately needed.

OHA routinely receives pleas for assistance from Connecticut consumers faced with carrier's denial of coverage for treatment of their child's SUD or other mental health condition (or both) that is not based on generally accepted standards of medical practice and recommending levels of treatment that are not considered to be clinically appropriate by the child's treating clinicians. As an example, one client was admitted to a Residential Treatment Center (RTC) following increasingly dangerous and frequent substance abuse that culminated in an overdose of Morphine necessitating emergency admission to the ICU and placement of a chest tube. This child was diagnosed with multiple substance abuse, as well as major depressive disorder and PTSD, following abuse years earlier. However, the initial reviewer, in citing the rational denying continued placement at the RTC, noted that the child was admitted for cannabis addiction *only,* and completely failed to consider the underlying co-morbidity which, as the clinical records indicated, was the likely precursor to this child's substance abuse. The reviewer recommended that, contrary to the findings of any of the clinicians who had actually met and

assessed this child, outpatient therapy would be appropriate. An excerpt from the denial of a subsequent relapse and readmission follows, comments embedded:

> *You went into this program to get rehabilitation for marijuana addiction* [not the primary diagnosis, merely the first on the list]. *You had recently left a residential program after 90 days of treatment* [which was also not covered]. *You had been getting treatment in an intensive outpatient program* [unsuccessfully, as the clinician noted on day one following discharge that the child was using, and had actually had arrived for the first session intoxicated. That clinician recommended immediate readmission into RTC]. *You were not attending after school programs or obeying rules at home to which you had agreed. You had relapses.* [This indicates a gross lack of capacity to manage the underlying triggers for the child's SUD and inability to comply with a treatment plan]. *This was not due to a mental health or medical problem for which you needed 24 hour supervision.* [The clinical notes clearly state that significant mental health issues existed that originated in and were exacerbated by the home environment and stressful family environment]. *You were not acting in a seriously dangerous manner. Your relapse could have also been treated in an outpatient program* [This child exhibited multiple very dangerous tendencies and relapsed *because* of the discharge from RTC and was aided in the relapse by a sibling. In fact, this child had continued to exhibit inclinations to use while in RTC, but <u>was discharged solely because the parents could not afford to continue to pay the extremely high costs. The father, as is very common, cashed in his retirement account to pay for his child's treatment</u>].

The denial concludes by stating that the decision was based on the plan's 2012 Behavioral Health Medical Necessity Criteria.

Another typical example of denial language used by insurers states, "You went into this program because you have been threatening <u>to stop harming yourself</u> (emphasis added). You have been looking for sharp objects. This has been going on for some time. You harm yourself when you are stressed. This behavior has not caused severe medical problems and is not likely to." This is not only blatantly contradictory and inaccurate (see underlined text), but inconsistent with medical guidelines. Nowhere do the criteria require *severe* medical problems as a factor for treatment.

Like many insurer decisions, the denials do not provide substantive information or a true rationale for the denial of care tied to the policy. Instead the carriers list facts, sometime inaccurately,

without any clear rationale, which denies the consumer a fair appeal. This is one of the reasons OHA is grateful that soon carriers will be required to produce the entire record of a case.

Insurers assert that the criteria that they apply to these cases are based on current psychiatric literature in addition to criteria promulgated by the American Psychiatry Association (APA), American Academy of Child and Adolescent Psychiatry(AACAP), the American Society of Addiction Medicine(ASAM), as well as other relevant sources. However, "the American Academy of Child and Adolescent Psychiatry's Practice Parameters for the Assessment and Treatment of Children and Adolescents with Substance Use Disorders concluded that it is essential to treat psychiatric disorders that are co-morbid with substance use disorders among adolescents, and that integration of psychotherapy and medication therapy is currently thought to be the best treatment of that population [and that]...treatment of dually diagnosed adolescents should include interventions for both disorders because lack of adequate treatment of one of the disorders might interfere with recovery."[3] Additionally, commonalities among various treatments indicates that retention in treatment results in improved outcomes.[4,5]

Complicating treatment for SUD is the increased prevalence of a psychiatric co-morbidity as an indicator of the child's risk. For example, in 2010, adolescents who had experienced a major depressive episode within the past year were more than twice as likely to use illicit drugs as those without the associated diagnosis.[6] Those who had suffered a major depressive episode were more than three times more likely to have also experienced clinical substance dependence during that year.[7] Also concerning is the national trend showing increasing substance abuse among this vulnerable population, with an increase from 9.3% of youths aged 12-17 in 2008 to 10.1% in 2010.[8] Given that SUD and co-occurring psychiatric diagnoses are triggered by internal and external stressors, it's not surprising that as more families have struggled during the ongoing economic downturn, statistics have identified this increase. This trend is clearly demonstrative of the fragility of this group's coping capabilities, which are critically important to adolescent's success in cessation and adherence to abstinence of substance abuse. However, when the appropriate level of treatment is denied or unavailable to these children, their ability to remain abstinent and develop adequate mechanisms for coping with their underlying co-morbidity is seriously compromised. In fact, two-thirds of adolescents entering treatment have suffered

from physical, sexual or emotional abuse in need of assessment and management, and remember that only 10-15% of those with SUD actually seek treatment.[9] Successful recovery requires "an environment that is supportive of recovery ...[and] when families are not healthy or supportive...teens can find recovery especially difficult to sustain."[10] It is vital that intervention be early and successful, because "the age of first use is correlated with the likelihood of becoming addicted and severity of substance use problems."[11]

It is evident that children suffering from SUD must receive clinically appropriate treatment of sufficient duration and early onset, but of adolescents in need of treatment for SUD, only 10% receive it and of those fortunate few, only 25% receive enough treatment to give them a reasonable chance at recovery.[12,13] While there remain a host of bases for this discrepancy, a critical component of this disparity remains a dearth of availability and affordability of programs. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) intended to correct this by requiring group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (like visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.[14] However, the effective date of MHPAEA was January 2010, and the subsequent passage and implementation of the Patient Protection and Affordable Care Act's regulations, with its highly complex and technical provisions, as well as the need for timely and voluminous guidance from many of the same agencies tasked with implementing MHPAEA, has severely curtailed effective action with MHPAEA. More than two years after its effective date, providers and carriers await final guidance concerning critical provisions of this act. Connecticut has demonstrated admirable initiative passing legislation mirroring the requirements of MHPAEA, stating that "No such ... policy shall establish any terms, conditions or benefits that place a greater financial burden on an insured for access to diagnosis or treatment of mental or nervous conditions than for diagnosis or treatment of medical, surgical or other physical health conditions."[15, 16]

However, due to the more clinically subjective measures associated with mental health and SUD, my office routinely sees a significantly greater portion of carrier denials for service founded on a lack of medical necessity than with medical claims, with said denials rarely finding support in the clinical

record or professional guidelines and criteria.

C.G.S. §38a-482a states that:

> "Medically necessary" or "medical necessity" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (1) In accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and (3) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For the purposes of this subsection, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment."

Factors for consideration of the appropriate treatment setting for adolescents are clearly detailed by multiple authorities with which the Behavioral Health Medical Necessity Criteria allege to comply. The AACAP states that:

> Factors affecting the choice of treatment settings include the following: (1) the need to provide a safe environment and the ability of the adolescent to care for him- or herself; (2) motivation and willingness of the adolescent and his or her family to cooperate with treatment; (3) the adolescent's need for structure and limit-setting that cannot be provided in a less restrictive environment; (4) the existence of additional medical or psychiatric conditions; (5) the availability of specific types of treatment setting for adolescent; (6) the adolescent's and his or her family's preference for a particular setting; and (7) treatment failure in a less restrictive level of care.[17]

The ASAM Patient Placement Criteria for the Treatment of Substance Disorders states that "the duration of treatment should always be determined by the progress of each individual patient.... Longer

exposure to treatment interventions is necessary for certain adolescents to acquire basic living skills and to master the application of coping and recovery skills."[18] Substance abuse is very frequently a means of self-medication of underlying and frequently undiagnosed co-morbidities utilized by adolescents and without adequate treatment of both, the child will be at substantially greater risk to relapse.[19]

Avoiding this is critically important – both for the long term physical and emotional health and well-being of the child and their family, as well as the economic viability of our healthcare system. Adequate method and duration of treatment as recommended by a treating clinician can dramatically improve an adolescent's long-term prognosis, but the flagrant disregard for accepted practice standards and criteria, jeopardizes patients' ability to recover as quickly and comprehensively as they can.

Logically, it would seem to make little sense for insurers to deny treatment that is clearly supported by the clinical record and guiding principles and criteria. The rote application of criteria is disturbing. When comorbities are present, carriers continue to apply criteria in a cookbook manner. A medical necessity determination is meant to be individualized, but is often not conducted in that manner. Improperly deciding medical necessity significantly increases the probability that the child will end up relapsing and requiring an even longer duration of care, in addition to the long term effects on their physiological development, resulting in additional healthcare expenses that must be borne by the insurer – unless they deny the claim and don't pay.

Within my office it's estimated that, of the cases related to substance abuse and co-morbidities, 60% are overturned at external appeal. This trend casts grave doubt on the efficacy of the insurer's internal mechanisms to adequately review and determine appropriate treatment protocols for their members. It's important to remember that by the time an appeal reaches external review, the claim has already been reviewed at least twice by the insurer, sometimes three times counting the initial claim review and denied each time.

How is it that only at the external review process do many patient's records and claims receive appropriate consideration? Several elements of the review process are implicated, first and most relevant being the background, training and experience of the reviewing physician. Under current

Connecticut law for internal reviews, insurers need only have a healthcare provider review the record, irrespective of specialization or ability to adequately assess the clinical records. This defect creates an environment that permits providers who may not be qualified to assess a claim's fitness. C.G.S. §38a-591(l)(c)(4) addresses this flaw for external appeals, stating, in relevant part, that the insurer must:

> (4) Assign as a clinical peer a health care professional who meets the following minimum qualifications:
>
> (A) Is an expert in the treatment of the covered person's medical condition that is the subject of the review;
>
> (B) Is knowledgeable about the recommended health care service or treatment **through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person**; (emphasis added)

Given the large number of plan types and varying applicable law, appeal rights and timeframes may vary, but many insurers' denial letters merely specify the procedure for each plan type without expressly stating which applies to the member. This effectively deprives the consumer of the ability to recognize their appeal rights under law. Even for those who initiate the appeals process, it is a difficult road. OHA received 407 cases requesting assistance with appeals in 2011 and so far this year, OHA has received 191 requests from people seeking help obtaining coverage for mental health and substance use disorders. Absent timely coverage by the carriers, the extremely high cost of treatment and recovery necessitated that many of these families take out second mortgages or withdraw from their retirement accounts, sometimes even losing their homes. This cannot continue.

Countless examples of insurer non-compliance with basic clinical guidelines, to which they purport to adhere, as well as MHPAEA, highlight the need for additional action. The Employee Benefits Security Administration (EBSA) noted a common violation involved charging specialist co-pays for routine mental health services, but generalist co-pays for comparable medical care.[20] One insurer imposed a requirement in the medical necessity assessment without foundation in any professional guidelines and inconsistent with state law that resulted in the improper denial of coverage. This practice resulted in many consumers going without desperately needed treatment for the duration of

the appeals process which, because the insurer based its denial on its own criteria, frequently had to reach the external appeal level, where a majority of the time, an independent clinician reviewed the case and overturned the denial.

Unfortunately, all too often, the time required for this process to run its course results in a significant deterioration in the condition of the affected individual. The child in the previous example left RTC due to financial constraints before the clinicians felt it was appropriate, a sentiment echoed by this child's IOP clinician. He is now into a third stay in RTC because the treatment plan his therapists designed was interrupted by his premature discharge – twice – due to lack of finances and denial of services by his carrier. After 7 months, the appeals process is nearing completion.

Another case involved a young man who had suffered with severe psychiatric problems as well as chronic and intense SUD. Despite clear adherence to all accepted clinical criteria, the carrier denied admission to an out of network RTC following an inpatient admission for an overdose, stating that he had improved. One reason that he was referred to an out of state facility is that the insurer's in-network facilities refused to accept him due to his acuity and complex, dual diagnosis. A very common justification my office receives is that the patient had improved, completely ignoring the fact that the sole reason that there was improvement was due to them being admitted to a highly structured environment with constant supervision.

Indeed, this young man had, according to the carrier, also improved and no longer demonstrated symptoms consistent with medical necessity for RTC, despite letters and clinical notes to the contrary. Following several months of unsuccessful appeals and years of treatment attempts that were thwarted at each step by the insurer, this young man was discharged from his treatment facility because his parents could no longer afford the tens of thousands of dollars it had cost them. Almost immediately, he disappeared. A month later, his parents finally located him in NYC. He eventually agreed to meet them in the train station. It was clear to them their son was homeless and struggling psychiatrically. It was only because he had a serious injury on his hand that had become septic that he agreed to go to the ER. While at the hospital the family requested that he be psychiatrically evaluated and he was found to be actively psychotic and grossly impaired. Following a short admission to stabilize his disease and restart his medication, the insurer determined that he no longer met the criteria for that

level of care, stating that he no longer posed a risk to himself and denied coverage, once again, despite the recommendations of the clinicians who were treating him and had considered his entire history.

One final example involves the similar situation of a young girl who had suffered sexual abuse early in life and had turned to drug abuse as a means of dulling her untreated pain. Years of failed therapy, frequently denied or second-guessed by the insurer, manifested in increasingly self-destructive and aggressive behavior, escalation in the frequency and severity of her drug use, and several incidents where she would disappear for weeks or months at a time. Her parents cashed in their retirements to cover what the insurer didn't but, as is all too common given the exorbitant cost of treatment, could no longer pay for ongoing treatment because, despite what her therapist's warnings, the insurer considered it not to be medically necessary. She had been progressing well, and had held onto a part time job for several months. Following the interruption of her treatment, she once again began to spiral down, losing her job, shunning contact with family until, eventually, her mother found her one day, three days dead from an overdose in her bathtub.

It is critically important that clinicians be able to determine what is medically necessary for their patients, not the insurer.

Thank you for providing me the opportunity to deliver OHA's testimony today. If you have any questions concerning my testimony, please feel free to contact me at victoria.veltri@ct.gov.

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[9] Giridharas, S. Office of Nation Drug Control Policy, Office of Demand Reduction, *Adolescents and relapse: A guide to overcoming relapse triggers,* 2011.

[10] Ibid. @ 3.

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[12] Center for Substance Abuse Treatment. "Treatment Episode Data Set (TEDS)".

[13] Substance Abuse and Mental Health Services Administration; National Institute on Drug Abuse. "Monitoring the Future (MTF)"

[14] United States Department of Labor, MHPAEA Fact Sheet, http://www.dol.gov/ebsa/newsroom/fsmhpaea.html Published January 29, 2010, Accessed June 22, 2012.

[15] C.G.S. §38a-514(b) (2012).

[16] C.G.S. §38a-488(a) (2012).
[17] AACAP *Practice Parameters for the Assessment and Treatment of Children and Adolescents with Substance Abuse Disorders,* Recommendation 6.

[18] ASAM, *Patient Placement Criteria for the Treatment of Substance Disorders,* p. 241.

[19] Giridharas @ 7.

[20] U.S. Department of Labor, Employee Benefits and Security Administration. *2012 report to congress: Compliance with the mental health parity and addiction equity act of 2008.* Retrieved from website: http://www.dol.gov/ebsa/publications/mhpaeareporttocongress accessed June 22, 2012.